BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: JOSIAH F. Claimant, vs. ALTA CALIFORNIA REGIONAL CENTER, Service Agency.	OAH No. 2010040052

DECISION

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings, on November 16, 2010, in Auburn; and on December 16, 2010, in Sacramento, California.

Robin M. Black, Legal Services Specialist, represented the service agency.

Lynne Castellucci, Developmental Disabilities Area Board III, represented claimant.

Submission of the matter was deferred pending receipt of written argument. Service Agency's Closing Brief and Claimant's Closing Argument were received on January 12 and 18, 2011, and marked respectively as Exhibits 34 and I. Claimant's Rebuttal and Service Agency's Reply to Claimant's Closing Brief were received on January 19 and 21, 2011, and marked respectively as Exhibits J and 35. The matter was submitted for decision on January 21, 2011.

ISSUES

1. Is claimant eligible to receive regional center services and supports by reason of a diagnosis of autism?

2. If claimant is not eligible for regional center services under the categories of autism or mental retardation, is he eligible under the "fifth category" because he has a condition closely related to mental retardation, or that requires treatment similar to that required for individuals with mental retardation?

FACTUAL FINDINGS

Background and History

1. Claimant is a 20-year-old man. His then foster parents first applied for Early Start services through Alta California Regional Center (ACRC) in June 1991 when claimant was age nine months. A physician referred claimant to ACRC because of suspicion of Fetal Alcohol Syndrome at that time. Claimant's medical records indicated a positive test for ethanol at birth. ACRC's developmental pediatrician, Richard Coolman, M.D., completed a developmental pediatrics evaluation of claimant on November 6, 1991, when claimant was 13 months old. Dr. Coolman observed no physical, neurological or developmental concerns to warrant a diagnosis of Fetal Alcohol Syndrome at that time. Dr. Coolman determined that claimant was showing age appropriate developmental progress, and did not appear to be at high risk for developmental disability. ACRC determined that claimant was not eligible for Early Start services on that basis.

2. In December 2009, through his now adoptive parents, claimant again applied for services from ACRC. He applied as an unconserved adult. The family's stated concerns were as follows:

> Concern is that he will require supports to live independently, forgets meds, cooks simple (Top Ramen), cannot calculate change, can make purchase, does not drive, can manage self-care tasks – forgets appts, etc. – special ed. all his life – depression, aggression, he says he goes into his own world during the day at times & then becomes agitated – at 12 yrs. Old, broke into gas station & took money.

3. Stan Gamba was the ACRC Intake Counselor assigned to perform a social assessment for claimant. He noted that claimant was referred to ACRC at the suggestion of Linda Michael, Psy.D., a psychological assistant with Victor Community Support Services, Inc. (VCSS). Dr. Michael had prepared a psychological evaluation report dated April 18, 2009, in which she diagnosed claimant with Major Depressive Disorder; Recurrent, Moderate on Axis I. She also diagnosed him with Fetal Alcohol Syndrome along Axis III. Dr. Michael suggested in her report that "referral for services at Alta Regional Center may be based on this evaluation." Claimant was receiving ongoing therapy and psychiatric care by VCSS

staff. He was prescribed several medications for treatment purposes. Mr. Gamba interviewed Dr. Michael, claimant's adoptive parents, and claimant's therapist, Lynette Weiss, LCSW. ACRC's staff physician, Terrance Wardinsky, M.D., performed a physical examination of claimant.

Based upon the results of the assessments by Dr. Wardinsky and Mr. Gamba, and other information available to ACRC's interdisciplinary team, claimant's request for ACRC services was denied on February 22, 2010. Claimant and his parents now appeal from this decision. They contend that claimant is eligible for regional center services based either upon a diagnosis of autism, or based upon his having a condition closely related to mental retardation, or requiring treatment similar to that required by individuals with mental retardation.

4. Under the Lanterman Act, ACRC accepts responsibility for persons with developmental disabilities. A developmental disability is a disability that originates before age 18, that continues or is expected to continue indefinitely and that constitutes a substantial disability for the individual. Developmental disabilities include mental retardation, cerebral palsy, epilepsy, autism and what is commonly known as the "fifth category" – a disabling condition found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals. (Welf. & Inst. Code, § 4512, subd. (a).) Given the disjunctive definition – a condition closely related to mental retardation or requiring similar treatment to that required for individuals with mental retardation – the fifth category encompasses two separate grounds for eligibility.

Autistic Spectrum Disorder Evaluation

5. Dr. Michael prepared a Psychological Report – ADDENDUM, purporting to update her April 18, 2009 psychological evaluation. She noted in the addendum that she had updated her differential diagnosis for claimant and it "appropriately includes in his Axis I Diagnosis, 299.80 Pervasive Developmental Delay, Not Otherwise Specified. The purpose of this is to identify that Josiah's level of functioning with Fetal Alcohol Syndrome presents behaviorally as PDD, NOS criteria." In support of her additional diagnosis, Dr. Michael noted the following:

> As with Pervasive Developmental Delay, showing severe and pervasive impairment in the development of reciprocal social interaction, Josiah shows compromised social interactions, is not able to identify a problem situation beyond only primitive or basic recognition expressed in vague terms. Additionally, he shows that he may not have the executive, adaptive functioning skills to perceive the consequences of his behavior. Josiah has difficulty with mental representation problems that make it difficult for him to grasp an understanding of typical human interactions. He struggles with a poor ability to understand the

> perspective of others, their facial expressions. While Josiah may show through cognitive assessment that he may possess the ability necessary for the performance of daily activities, his adaptive behavior is inadequate because this ability is not demonstrated when it is required due to his Pervasive Developmental Delay.

6. Dr. Michael's addendum was not provided to ACRC for review during the eligibility process. At hearing, Dr. Michael acknowledged that she has no specialized background or knowledge in PDD-NOS, and that she had no supporting information regarding claimant's impairment in development of reciprocal social interactions. Dr. Michael attributed her failure to include PDD-NOS in her original evaluation to "intern error." Dr. Michael is a psychological assistant who is working under the supervision of Chris Boudoures, Psy.D. Dr. Boudoures signed Dr. Michael's original evaluation, but not Dr. Michael's addendum.

7. PDD-NOS is not autism. Section 299.00 of the DSM-IV TR, beginning at page 70, concerns autistic disorder. To diagnose autistic disorder, one must find that the individual has qualitative impairments in social interaction; at least one qualitative impairment in communication; and at least one restricted repetitive and stereotyped pattern of behavior, interest, or activity. One must find a total of at least six of these items. One must find that the impairments in social interaction and communication are marked and sustained. One also must find that there are delays or abnormal functioning, with an onset prior to three years, in social interaction, language as used in social communication, or symbolic or imaginative play. No evidence was offered to establish that claimant meets these diagnostic criteria.

It was not demonstrated through other evidence, oral or documentary, that claimant has autism. Accordingly, claimant is not eligible for ACRC services based upon a diagnosis of autism.

Fifth Category

8. In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, the appellate court held that "the fifth category condition must be very similar to mental retardation, with many of the same, or close to the same, factors required in classifying a person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well." (*Id*. at p. 1129.) It is therefore helpful to review the factors required for a diagnosis of mental retardation. The DSM-IV provides that the "essential feature of Mental Retardation is significantly subaverage general intellectual functioning…." It must be accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.

Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below – approximately two standard deviations below the mean. It is undisputed that claimant's general intellectual functioning is not significantly subaverage. He does not show borderline intellectual functioning, nor anything near subaverage intellectual functioning. He is in the average range of intellectual functioning. In fact, claimant passed the California Assessment High School Exit Exam in the area of English Language on November 4, 2008. He passed Algebra I and was participating in a high school curriculum leading to a diploma. He graduated from high school with a diploma, suggesting that he passed the Math Exit Exam as well.

9. That claimant does not have this "essential feature" of mental retardation is not in dispute. Claimant contends, rather, that he is eligible because deficits in his adaptive functioning suggest either that he has a condition closely related to mental retardation, or that he requires services or treatment similar to that received by individuals with mental retardation. Fifth category eligibility determinations typically begin with a threshold consideration of whether an individual had deficits in intellectual functioning. This is done prior to consideration of other fifth category elements related to similarities between the two conditions, or the treatment needed. Claimant seeks to bypass such threshold consideration of intellectual functioning, and focus instead on his significant limitations in adaptive functioning, and need for services similar to that provided to individuals with mental retardation.

10. A recent appellate decision has suggested, when considering whether an individual is eligible for regional center services under the fifth category, that eligibility may be based largely on the established need for treatment similar to that provided for individuals with mental retardation, and notwithstanding an individual's relatively high level of intellectual functioning. (*Samantha C. v. State Department of Developmental Services* (2010) 185 Cal.App.4th 1462.) In *Samantha C.*, the individual applying for regional center services did not meet the criteria for mental retardation. Her WAIS-III test results scored her above average in the areas of abstract reasoning and conceptual development and she had good scores in vocabulary and comprehension. She did perform poorly on subtests involving working memory and processing speed, but her scores were still higher than persons with mental retardation. The court understood and noted that the Association of Regional Center Agencies had guidelines which recommended consideration of fifth category for those individuals whose "general intellectual functioning is in the low borderline range of intelligence (I.Q. scores ranging from 70-74)." (*Id.* at p. 1477.) However, the court confirmed that individuals may qualify for regional center services under the fifth category on either of two independent bases, with one basis requiring only that an individual require treatment similar to that required for individuals with mental retardation. Here, claimant believes he requires treatment similar to that required for individuals with mental retardation. He also believes that his condition is closely related to mental retardation.

Fifth Category Eligibility – Condition Closely Related to Mental Retardation

11. Claimant seeks eligibility based upon his condition being closely related to mental retardation, his primary focus being upon his impairments in adaptive functioning. Adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting.

The well-documented record demonstrated that claimant is not effectively coping with common life demands and that he does not meet standards of personal independence expected of a young man in his community. His adaptive functioning is substantially impaired. He was administered the Vineland Adaptive Behavior Scales – Second Edition (Vineland-II). The Vineland-II is a standardized interview for quantifying a parent's observations and information about their child. It provides a comprehensive assessment of adaptive behavior and a systematic basis for preparing individual educational, rehabilitative, or treatment programs. Dr. Michael noted that claimant "consistently shows Low/Moderately Low levels of adaptive functioning in all assessed domains."

12. ACRC does not dispute that claimant has deficits in adaptive functioning. Rather, ACRC notes that such deficits may have a number of causes, including education, motivation, personality characteristics, social and vocational opportunities, and mental disorders and general medical conditions. And ACRC notes that deficits in adaptive behavior may occur in the absence of significant deficits in general cognitive ability. In this case, claimant has been diagnosed at various times with major mental health disorders. His diagnoses have included ADHD, Bipolar Disorder with Psychotic Features, Pervasive Developmental Disorder, NOS, and Major Depressive Disorder.

There appear to have been other psychosocial and environmental factors that have affected claimant's adaptive functioning. For example, Don Stembridge, Ph.D., conducted a psychological evaluation of claimant on October 29, 2004, in connection with determining whether claimant had mental disorders that factored in his involvement in criminal activities. Dr. Stembridge diagnosed claimant with Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features. Under Axis IV, Dr. Stembridge noted the following psychosocial and environmental problems: incarcerated in juvenile hall, facing charges, mother has serious illness causing parental role change, peer rejection and teasing. Such factors have no relationship to deficits in general cognitive ability.

13. Phyllis S. Magnani, Ph.D. is a staff psychologist with ACRC. She opined that the observed deficits in claimant's adaptive functioning are likely caused by his mental health problems. She believes that his concerning behaviors are not consistent with fifth category eligibility because he has a level of insight and

understanding, usually after the fact, that what he did was wrong. Dr. Magnani considers his impulsivity and poor executive functioning as paramount problems. She relates neither to any cognitive deficits. Dr. Magnani noted claimant's significant mental health problems at an early age. For example, at age five, claimant was suicidal and paranoid. She opined that his very low adaptive functioning might be explained solely by mental health diagnoses. And if this is the case, she believes that such deficits are best addressed through medications.

14. There is no evidence that the deficits in claimant's adaptive functioning are related to any cognitive deficits. In this respect, it does not parallel traditional fifth category analysis that looks for subaverage intellectual functioning "accompanied by" significant limitations in adaptive functioning. Dr. Magnani's thinking on this matter is persuasive. If claimant's adaptive deficits indeed derive from his mental health diagnoses, such is inconsistent with a finding that his condition is closely related to mental retardation. Assuming Dr. Magnani's assessment is accurate, claimant's deficits in adaptive functioning are better addressed by medications or programs focused on his impulsivity and issues related to his executive functioning.

15. Alcohol-related Neurodevelopmental Disorders/Fetal Alcohol Syndrome. Dr. Wardinsky assessed claimant for possible Fetal Alcohol Syndrome and determined that he "certainly could have an alcohol-related neuro-developmental disorder in addition to other multiple diagnoses." Dr. Wardinsky opined that claimant has Fetal Alcohol Effect (FAE), something less than full Fetal Alcohol Syndrome (FAS). Dr. Wardinsky noted that this is not a condition similar to mental retardation. Individuals with FAE or FAS have a wide range of intellectual functioning. Some have mental retardation, but mental retardation is not required for a diagnosis of FAE or FAS. Alcohol-related Neurodevelopmental Disorders (ARND) is not listed as an associated feature or disorder of mental retardation in the DSM-IV. That prenatal damage due to maternal alcohol consumption may be a predisposing factor or cause of mental retardation does not necessarily imply that ARND is a condition closely related to mental retardation. In this case, given claimant's average range of intellectual functioning, it was not demonstrated that any ARND suffered by him manifests as a condition similar to mental retardation.

Fifth Category Eligibility – Condition Requiring Treatment Similar to that Required by Individuals with Mental Retardation

16. Fifth category eligibility may also be based upon a condition requiring treatment similar to that required for individuals with mental retardation. Preliminarily, "treatment" and "services" do not mean the same thing. They have separate meaning. Individuals without developmental disabilities, including those without any diagnosed disabilities, may benefit from many of the services and supports provided to regional center consumers. Welfare and Institutions Code section 4512, subdivision (b) defines "services and supports" as follows:

> "Services and supports for persons with developmental disabilities" means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives.

Regional center services and supports targeted at improving or alleviating a developmental disability may be considered "treatment" of developmental disabilities. Thus, section 4512 elaborates further upon the services and supports listed in a consumer's individual program plan as including "diagnoses, evaluation, *treatment*, personal care, day care, domiciliary care, special living arrangements, physical, occupational and speech therapy, training, education, supported and sheltered employment, mental health services,…" (Welf. & Inst. Code, § 4512, subd. (b). Italics supplied.) The designation of "treatment" as a separate item is clear indication that it is not merely a synonym for services and supports, and this stands to reason given the broader mission of the Lanterman Act:

> It is the intent of the Legislature that regional centers assist persons with developmental disabilities and their families in securing those services and supports which maximize opportunities and choices for living, working, learning, and recreating in the community.

(Welf. & Inst. Code, § 4640.7, subd. (a).)

17. Fifth category eligibility must be based upon an individual requiring "treatment" similar to that required by individuals with mental retardation. The wide range of services and supports listed under section 4512, subdivision (b), are not specific to mental retardation. One would not need to suffer from mental retardation, or any developmental disability, to benefit from the broad array services and supports provided by ACRC to individuals with mental retardation. They could be helpful for individuals with other developmental disabilities, or for individuals with mental health disorders, or individuals with no disorders at all. The Legislature clearly intended that an individual would have a condition similar to mental retardation, or would require *treatment* that is specifically required by individuals with mental retardation, and not any other condition, in order to be found eligible.

18. In *Samantha C.*, no attempt was made to distinguish treatment under the Lanterman Act as a discrete part or subset of the broader array of services provided to those seeking fifth category eligibility. Thus, the appellate court made reference to individuals with mental retardation and with fifth category eligibility

both needing "many of the same kinds of treatment, such as services providing help with cooking, public transportation, money management, rehabilitative and vocational training, independent living skills training, specialized teaching and skill development approaches, and supported employment services." (*Samantha C. v. State Department of Developmental Services, supra*, 185 Cal.App.4th 1462, 1493. Italics supplied.) This broader characterization of "treatment" cannot properly be interpreted as allowing individuals with difficulties in adaptive functioning, and who require assistance with public transportation, vocational training or money management, to qualify under the fifth category without more. For example, services such as vocational training are offered to individuals without mental retardation through the California Department of Rehabilitation. This demonstrates that it is not necessary for an individual to have mental retardation to demonstrate a need for services which can be helpful for individuals with mental retardation.

Individuals with mental retardation might require many of the services and supports listed in Welfare and Institutions Code section 4512, which could benefit any member of the public: assistance in locating a home, child care, emergency and crisis intervention, homemaker services, paid roommates, transportation services, information and referral services, advocacy assistance, technical and financial assistance. To extend the reasoning of *Samantha C.*, an individual found to require assistance in any one of these areas could be found eligible for regional center services under the fifth category. This was clearly not the intent of the Legislature.

Thus, while fifth category eligibility has separate condition and needs-based prongs, the latter must still consider whether the individual's condition has many of the same, or close to the same, factors required in classifying a person as mentally retarded. (*Mason v. Office of Administrative Hearings, supra*, 89 Cal.App.4th 1119.) Furthermore, the various additional factors required in designating an individual as developmentally disabled and substantially handicapped must apply as well. (*Id*. at p. 1129.) *Samantha C.* must therefore be viewed in context of the broader legislative mandate to serve individuals with developmental disabilities only. A degree of subjectivity is involved in determining whether the condition is substantially similar to mental retardation and requires similar treatment. (*Id*. at p. 1130; *Samantha C. v. State Department of Developmental Services, supra*, 185 Cal.App.4th 1462, 1485.) This recognizes the difficulty in defining with precision certain developmental disabilities. Thus, the *Mason* court determined: "it appears that it was the intent of those enacting the Lanterman Act and its implementing regulations not to provide a detailed definition of 'developmental disability' so as to allow greater deference to the [regional center] professionals in determining who should qualify as developmentally disabled and allow some flexibility in determining eligibility so as not to rule out eligibility of individuals with unanticipated conditions, who might need services." (*Id*. at p. 1129.)

For all the above reasons, the treatment needs of claimant will be viewed within the narrower context of those services and supports similar to and targeted at improving or alleviating a developmental disability similar to mental retardation.

19. Claimant's Treatment Needs. Dr. Michael made treatment recommendations based upon claimant's diagnosis of Fetal Alcohol Syndrome (FAS). She opined that for individuals diagnosed with FAS, as those who are diagnosed with developmental delay disorders, "tasks, activities, and/or projects may need to be broken down into smaller, more manageable segments, with frequent breaks, so as not to overwhelm Josiah." Dr. Michael believes this may facilitate his skills development that may benefit the appropriate and successful completion of his school work, as well as independent skills development, enhancing his self esteem. Some of Dr. Michael's more specific recommendations are set out below:

- Teach and demonstrate skills; provide opportunities to practice skills; relaxation training to mediate performance anxiety; frequent reminders/repetition of the use of these skills.
- Encourage independent living skills development, using small incremental steps, with frequent repetition.
- Develop a skill set of self-care tools, aiding Josiah's confidence in his own abilities.
- Cognitive-Behavioral identification of hazards/risks in the environment and choices/options available in such situations. Repetition of cues may be needed.
- Behavioral treatment may need to focus on placing a stronger emphasis on interventions that attend to problem-solving, and to issues of inhibition, flexibility, and/or emotional control.

20. Dr. Magnani testified to the treatment typically afforded those individuals with mental retardation or low global intellectual functioning. It consists of: breaking down information into small segments, slowing the rate of introduction of concepts, and use of repetition. Individuals with mental retardation need this approach in all or almost all areas of learning. The provision of any service or support to an individual with mental retardation would necessarily differ significantly in manner and delivery from that provided to an individual with average general intelligence. In this respect, individuals with mental retardation would be "treated" differently and thus require different "treatment" than individuals with average general intelligence.

21. The matters testified to by Dr. Magnani, and set forth in Findings 13 and 14, have also been considered and determined to be persuasive. Dr. Magnani is a licensed clinical psychologist with over 10 years experience in assessing and evaluating individuals for the presence of developmental disabilities. She has completed thousands of assessments for developmental disabilities. Dr. Magnani believes that claimant's deficits in adaptive functioning arise from mental health

issues. Claimant has been diagnosed at various times with psychiatric disorders and learning disabilities, including: ADHD, learning disabilities, Bipolar Disorder with psychotic features, and Major Depressive Disorder. His reported behavioral issues appear to be directly related to his mental health disorders, including: inattention in class, stealing/theft/shoplifting, vandalism, manic episodes, auditory hallucinations, inappropriate sexual behavior, damaging furniture in the home, and enuresis. Criminal activity increased when he was noncompliant with medications prescribed for his psychiatric conditions.[1]

Claimant's parents reported that claimant experienced suicidal ideation and paranoid ideation in grade three, and in grade six he was diagnosed with schizoaffective disorder. He presented then as depressed and suicidal, and noted hearing voices. After he destroyed furniture at home he was briefly placed in Sutter Psychiatric Hospital. There are reports of manic episodes when he became destructive and grandiose, and engaged in magical thinking. Claimant reported vague visual hallucinations, compulsions to steal and following voices in his head. A court-appointed psychologist determined that claimant's mental disorders were a factor in his criminal activities. He recommended that claimant's medication compliance be closely monitored, with early intervention to head off any manic episodes.

22. The above matters have been considered, along with the relative experience and expertise that Dr. Magnani and Dr. Michael have in assessing individuals with developmental disabilities. This is a case where deference should properly be given to ACRC professionals in determining eligibility. (*Mason v. Office of Administrative Hearings, supra*, 89 Cal.App.4th 1119, 1129.) Claimant's witnesses were not specialists in the field and did not have the educational or professional experience commensurate with Dr. Magani or Dr. Wardinsky. It does appear that claimant's adaptive behavior deficits arise from his severe psychiatric disorder, and not a developmental disability. Under these circumstances, it cannot be found that he requires treatment similar to that received by individuals with mental retardation.

23. In reaching this conclusion, it was also determined that claimant did not demonstrate that treatment for individuals with ARND is similar to treatment for individuals with mental retardation. Dr. Magnani summarized recommendations for treatment of FAS disorders published by the Center for Disease Control (CDC). She noted that the CDC focused upon five interventions that specifically addressed the neurodevelopmental needs of children with FAS disorders. In conjunction with other treatments recommended by the CDC for individuals with FAS disorders, these interventions represent the best clinical opinion about recommended treatment for

[1] Claimant's prescribed medications show the severity of his psychiatric conditions. He was placed on Ritalin at age five, and also on Tenex for impulsivity. The Ritalin was changed to Adderall. At age eight or nine, he was placed on Depakote for impulsivity.

FAS disorders. Dr. Magani opined that these treatments are not the same or similar to those required by individuals with mental retardation. In fact, the more promising recommendations and approaches for adults with ARND are not treatment at all, but look rather to supportive services including: guardianship, subsidized residential placement, in-home support services, specialized vocational training and job placement, and medical care.[2]

24. It was not established that claimant is eligible to receive regional center services and supports by reason of a condition found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation. Claimant does not have a condition that is closely related to mental retardation. He has average general intellectual functioning. Assessment of his ARND is not suggestive of it being a condition similar to mental retardation. Approximately 25 percent of individuals with ARND suffer from mental retardation. However, the vast majority demonstrate average intellectual functioning as in claimant's case. Claimant has significant deficits in adaptive functioning. However, these deficits do not result from any deficits in general cognitive ability. They likely result from difficulties with attention and impulsivity characteristic of ADHD, which may be exacerbated by Bipolar Disorder with psychotic features and Major Depressive Disorder. These are psychiatric disorders requiring mental health treatment very different than that provided for individuals with mental retardation. As such, they are not developmental disabilities as defined under the Lanterman Act and claimant does not qualify for services through ACRC.

LEGAL CONCLUSIONS

1. Under the Lanterman Developmental Disabilities Services Act, the State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. (Welf. & Inst. Code, § 4501.) As defined in the Act a developmental disability is a disability that originates before age 18, that continues or is expected to continue indefinitely and that constitutes a substantial disability for the individual. Developmental disabilities include mental retardation, cerebral palsy, epilepsy, autism, and what is commonly known as the "fifth category" – a disabling condition found to be closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals. (Welf. & Inst. Code, § 4512, subd. (a).)

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[2] The CDC has indicated that there are no medications approved specifically to treat FASDs. However, some medications may help address some of the symptoms of FASDs; including managing high energy levels, increasing ability to focus, and alleviating depression.

Handicapping conditions that consist solely of psychiatric disorders, learning disabilities or physical conditions do not qualify as developmental disabilities under the Lanterman Act. (Cal. Code Regs., tit. 17, § 54000, subd. (c).)

2. "Substantial handicap" is defined by regulations to mean "a condition which results in major impairment of cognitive and/or social functioning." (Cal. Code Regs., tit. 17, § 54001, subd. (a).) Because an individual's cognitive and/or social functioning is multifaceted, regulations provide that the existence of a major impairment shall be determined through an assessment that addresses aspects of functioning including, but not limited to: 1) communication skills, 2) learning, 3) self-care, 4) mobility, 5) self-direction, 6) capacity for independent living and 7) economic self-sufficiency. (Cal. Code Regs., tit. 17, § 54001, subd. (b).)

3. It was not established that claimant has a developmental disability that originated before age 18 and that continues, and that constitutes a substantial disability for him. He does not have autism. (Findings 5 through 7.) He does not have a disabling condition closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals. (Findings 11 through 24.)

4. It was not established that claimant suffers from cerebral palsy, autism, mental retardation or otherwise qualifies under the fifth category. Claimant is therefore not eligible to receive services through Alta California Regional Center.

ORDER

Claimant's appeal from the Alta California Regional Center's denial of services is denied. Claimant is not eligible for services under the Lanterman Act.

DATED: February 24, 2011

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JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter. Each party is bound by this decision. An appeal from the decision must e made to a court of competent jurisdiction within ninety (90) days of receipt of the decision. (Welf. & Inst. Code, § 4712.5, subd. (a).)